DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 1 0

2. STATE: Louisiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 8, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201; 447.302

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ (103.66)
b. FFY 2001 $ (160.04)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Item 19, p1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN 99-06)

10. SUBJECT OF AMENDMENT: The purpose of this amendment is to reduce the fixed monthly reimbursement rate for Targeted Case Management services for Infants and Toddlers, HIV Infected Persons and High Risk Pregnant Women by seven percent (7%). Implementation is necessary to avoid a budget deficit in the state Medicaid Program.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Governor does not review state plan material

12. SIGNATURE OF STATE AGENCY OFFICIAL:
David Hood by John McCon

13. TYPED NAME:
David W. Hood

14. TITLE:
Secretary

15. DATE SUBMITTED:
March 24, 2000

16. RETURN TO:
State of Louisiana
Department of Health & Hospitals
1201 Capitol Access Road
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
03-31-2000

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
February 8, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Sandra Lee

21. TYPED NAME:
for Calvin G. Cline

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION	Medical and Remedial Care and Services	OPTIONAL TARGETED CASE MANAGEMENT SERVICES
42 CFR 447.201 447.302	Item 19	**REIMBURSEMENT METHODOLOGY**

Case Management services for Mentally Retarded/Developmentally Disabled Waiver recipients are reimbursed at a negotiated provider specific monthly rate in accordance with the terms of the contract.

Services are reimbursed at ninety three per cent (93%) of the fixed monthly rate in effect as of February 7, 2000 for the following targeted populations: Infants and Toddlers, HIV Infected Persons and High Risk Pregnant Women.

Payments made to providers do not duplicate payments for the same or similar services furnished by other providers or under other authority as an administrative function or as an integral part of a covered service.

Reimbursement is not available for case management services that are furnished to recipients without charge by any other agency or entity. With the statutory exceptions of case management services included in Individualized Educational Programs (IEP'S) or Individualized Family Service Plans (IFSP'S) and services furnished through Title V public health agencies, payment for case management services cannot be made when another third party payor is liable, nor may payments be made for services for which no payment liability is incurred by the recipient.

STATE Louisiana DATE REC'D 03-31-2000 DATE APPV'D 06-06-2001 DATE EFF 02-05-2000 HCFA 179 LA-00-10	A